88-1805

No. .....

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1988

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EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION; EASTERN NEBRASKA HUMAN SERVICES AGENCY; MICHAEL ALBERT; DONALD CLAASEN; RONALD HINELINE; RAY LIND; HILTON ROGERS, In Their Capacities as Members of the Governing Board of the Eastern Nebraska Human Services Agency; RAY CHRISTENSEN, In His Capacity as Executive Director of the Eastern Nebraska Human Services Agency; DONALD MORAY, In His Capacity as Executive Director of the Eastern Nebraska Community Office of Retardation,

Petitioners,

vs.

PATRICIA ANN GLOVER; MICHAEL R. MACRANDER; SUSAN I. DAVIDSON; MARY ST. GEORGE; REBECCA A. DEMUTH; TIMOTHY SIKORA; DAPHNE HOLMES; SHAWNE A. KINSMAN; DANIEL B. CHAMP, On Behalf of Themselves and all Other Persons Similary Situated,

Respondents,

THE AMERICAN PUBLIC HEALTH ASSOCIATION,

Amicus Curiae.

—o—

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

—o—

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QUESTIONS PRESENTED FOR REVIEW

1. Whether a governmental agency, regulated by the State and statutorily mandated with the care, custody, and safety of mentally retarded citizens, must have probable cause of infection or proof of transmission to conduct mandatory blood tests for specified infectious communicable diseases on employees in identified job classifications.

2. Whether a mandatory testing policy for specific infectious, communicable diseases solely for the safety of employees and those mentally retarded citizens receiving services from a governmental agency violates the privacy interest of those covered employees.

LIST OF PARTIES

The parties to the proceeding below were the Petitioners,

EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION; EASTERN NEBRASKA HUMAN SERVICES AGENCY; MICHAEL ALBERT; DONALD CLAASEN; RONALD HINELINE; RAY LIND, HILTON ROGERS, In Their Capacities as Members of the Governing Board of the Eastern Nebraska Human Services Agency; RAY CHRISTENSEN, In His Capacity as Executive Director of the Eastern Nebraska Human Services Agency; DONALD MORAY, In His Capacity as Executive Director of the Eastern Nebraska Community Office of Retardation,

and the Respondents,

PATRICIA ANN GLOVER; MICHAEL R. MACRANDER; SUSAN I. DAVIDSON; MARY ST. GEORGE; REBECCA A. DEMUTH; TIMOTHY SIKORA; DAPHNE HOLMES; SHAWNE A. KINSMAN; DANIEL B. CHAMP, On Behalf of Themselves and all Other Persons Similarly Situated,

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Petitioners,

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Respondents,

THE AMERICAN PUBLIC HEALTH ASSOCIATION,

Amicus Curiae.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

To: The Honorable: The Chief Justice and Associate Justices of the Supreme Court of the United States:

Your Petitioners, Eastern Nebraska Community Office of Retardation; Eastern Nebraska Human Services Agency; Michael Albert; Donald Claasen; Ronald Hineline; Ray Lind; Hilton Rogers, In Their Capacities as Members of the Governing Board of the Eastern Nebraska Human Services Agency; Ray Christensen, In His Capacity as Executive Director of the Eastern Nebraska Human Services Agency; Donald Moray, In His Capacity as Executive Director of the Eastern Nebraska Community Office of Retardation, respectfully petition for a writ of certiorari to review the judgment and decision of the United States Court of Appeals for the Eighth Circuit entered in the above action on February 6, 1988.

OPINIONS BELOW

The opinion of the United States Court of Appeals (App., infra, 23) is reported at 867 F.2d 461. The opinion of the United States District Court (App., infra, 3) is reported at 686 F.Supp. 243 (D.Neb. 1988).

GROUNDS FOR JURISDICTION

The judgment sought to be reviewed is the judgment of the United States Court of Appeals for the Eighth Circuit (App., infra, 23) entered on February 6, 1989.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

This case involves the following constitutional and statutory provisions:

(1) The Fourth Amendment to the United States Constitution provides that:

> "The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures."

(2) Section One of the Fourteenth Amendment to the United States Constitution provides, in relevant part:

> " . . . . No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

STATEMENT OF THE CASE

(1) This case arose out of a suit brought by employees of the Eastern Nebraska Community Office of Retardation, hereinafter referred to as Respondents. Respondents sought an injunction on behalf of all current employees in certain classified job positions against implementation of a chronic infectious disease testing policy. (App., infra at 30-40) The policy requires certain employees to submit to mandatory testing for tuberculosis (TB), hepatitis (HBV) and human immunodeficiency virus (HIV). (App., Infra. at 30-31)

Petitioner, the Eastern Nebraska Human Service Agency (ENHSA) was established pursuant to the Nebraska Interlocal Cooperation Act, Nebraska Revised Statutes § 23-2201, et seq. (App. Infra at 5) Petitioner, the Eastern Nebraska Community Office of Retardation (ENCOR) is a part of ENHSA and is organized under Nebraska Revised Statute Sections 83-1, 141 through 83-1,

146. App., infra at 5[1] Petitioner ENCOR, the nation's largest community based system providing comprehensive programs and services for every level of mental retardation and disability, was created in 1969 with the legislative enactment by the State of Nebraska of a statewide system of community based services for Nebraska. (Trial Transcript 337:16 - 340:15; 534:20-24)

Petitioner provides its services to mentally retarded citizens under detailed performance standards of the State of Nebraska through its Office of Mental Retardation, Department of Health, and Department of Social Services regulating every aspect of Petitioners' operation of services. (Trial Transcript 432:23 - 435:17) (Defendants' Ex. 122, 123, 124)

Approximately six hundred mentally retarded citizens are entrusted into the care of Petitioners. (App., infra at 7)[2] Five hundred are considered active clients for whom Respondent provides either a permanent home or vocational training or both. (Trial Testimony 428:1 - 429:3) (Defendants' Ex. 130)

Residential services consist of either a group home, staffed on a twenty-four hour basis by Petitioners' em-

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1 Other Petitioners include Michael Albert, Donald Claasen, Ronald Hineline, Ray Lind and Hilton Rogers, duly elected county commissioners, representing each county making up Region VI, Ray Christensen, Executive Director of ENHSA, and Donald Moray, Executive Director of ENCOR.

2 The trial court's finding that ENCOR serves approximately 600 mentally retarded, ranging in level from mild to profound (App. at 7) is a superficial overview of Petitioners' clientele. App., infra at 50-53 regarding the demographics of the client population.

ployees described as residential assistants and residential associates, or living in a private employee's home classified as a home teacher. (App. infra, 11) (Defendants' Ex. 12, 106, 123)

From a medical needs perspective, the mentally retarded citizens receiving care from Petitioners is highly complicated and at much greater risk than the general population. Over one-third has associated major medical problems. Eighty-five have Down's Syndrome with significant immunological deficiencies. (App. infra 44-47, 55-57)

In 1975, the State of Nebraska, pursuant to a consent decree in *Horacek v. Exxon,* — F.Supp. (D.Neb. 1975) (CV 72-L-220), initiated a policy of deinstitutionalization of its institutions for the mentally retarded. (Defendants Ex. 123) Consequently, the mentally retarded being served has become more complex not only as to the level of retardation and medical problems, but also behavioral problems. (App. infra 50) (Trial Transcript 676:6 - 682:10)

Since 1982, there have been over three hundred incidents of aggressive behavior of biting and scratching sufficient to file workmen compensation reports with 10% resulting in blood being drawn. (Defendants' Ex. 132)

In July of 1987, Petitioner learned that two mentally retarded citizens who had been placed from a private care facility for the mentally retarded into the state institution had preliminarily tested positive for HIV. (Infra, App. 11)

Two months earlier, in May, Petitioner had taken into its care fifteen mentally retarded citizens from the same

private facility to avoid their return to the state institution. (Trial Transcript 359:24 - 360:10)

In September of 1987, an employee of Petitioner died from AIDS. (Infra, App. 11)

At the Governing Board meeting of September 1987, the Governing Board instructed Donald Moray, Executive Director of ENCOR, to develop a policy for testing employees who were more directly involved with clients and clients receiving services for certain infectious communicable diseases, specifically tuberculosis, Human Immunodeficiency Virus (HIV) and HBV. (Infra, App. 5 & 11) The purpose for developing the testing policy was to ensure a safe work environment for all employees (Infra, App. 30) and a safe training and living environment for mentally retarded citizens entrusted to the care of Petitioners. (Infra, App. 30 & 31) After initial testing, annual testing would occur as part of the employee's annual physical exam. (Infra, App. 34 & 41-43)

Petitioners also adopted and implemented for all its vocational facilities universal precautions suggested by the Center for Disease Control and commenced training of its employees to ensure that CDC precautions were understood and correctly implemented. (Trial Transcript 358: 15-359:1)

On November 18, 1987, Petitioner, through its Governing Board, adopted Chronic Infectious Disease Policy 8.85. (Infra, App. 2) On January 20, 1988, an amended policy was approved as well as a policy for testing clients. (Infra, App. 4)

Respondent filed suit challenging the testing policy claiming various constitutional and statutory violations. On December 7, 1987 the Federal District Court issued a temporary restraining order, restraining all testing for HIV, HBV and tuberculosis. (Infra, App. 3) Respondents subsequently withdrew their objection to being tested for tuberculosis. (Infra, App. 4)

On March 29, 1988, the Federal District Court permanently enjoined testing employees for HIV and HBV. (Infra, App. 1-22) On February 6, 1989, the Eighth Circuit Court of Appeals affirmed that decision. (Infra, App. 23-29)

(2) The district court, in enjoining Petitioners' testing policy, made general findings first as to the reliability of the ELISA test and the Western Blot test utilized for testing for HIV. (App. Infra at 14)[3] The district court then made findings as to the risk of transmission of the HIV virus as extremely low. (App. Infra at 21) Disregarding all other evidence and based on this sole finding, the district court made similar findings about the risk of HBV transmission. (App. Infra at 21)[4] The court went on to contradict its own premise that transmission was the only factor, and found that even if Respondents' clients

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[3] The trial court totally ignored the unrebutted evidence of Petitioners that the actual testing laboratory to be utilized by Petitioners if allowed to test had no false-positives after administering the Western Blot test 250,000 times. Appl. infra 59-64.

[4] The medical testimony was in agreement that HBV is a much hardier virus and Respondents' own experts acknowledged an infection rate of 20% among health care workers. (Trial Testimony 239:2-240:23; 46:20-25; 47:1-6; 796:4-798:3)

were at risk at contracting HBV, a more intrusive method, mass immunization of Petitioners' clients with HBV virus,[5] would be a more appropriate measure. (App. Infra at 21)

(3) In affirming its award of relief, the Appeals Court summarily quoted the trial court's finding. App. Infra at 28. The Court seemed anxious, however, about its ruling and the consequence of it. App. Infra at 28.

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ARGUMENT AMPLIFYING REASONS FOR ALLOWANCE OF WRIT

This case presents a substantial federal question of public importance of whether a governmental agency to ensure the safety and health of mentally retarded citizens entrusted in its care may require mandatory blood testing of its employees to ascertain the presence of contagious communicable diseases. Concomitantly, this case asks the question whether a governmental employee has a constitutionally protected privacy interest in medical information of infection sought by the employer under an administrative scheme whose purpose is the safety of the em-

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[5] App. Infra at 46-47; Also Akhter, Stout and Twiehaus, *Hepatitis B Screening and Vaccination in a Facility for the Mentally Retarded,* 82 Missouri Med. 345 (1985) ("The high incidence of hepatitis B virus (HBV) among clients and staff of institutions for the mentally retarded is well documented"); (Boughton, Hawkey and Harlor, *The Epidemiology of Hepatitis B in a Residential Institution for the Mentally Retarded,* 6 Austr. NZJ Med. 1976); Follet, *Experience with Hepatitis B Vaccination in Nurses in a Hospital for the Mentally Handicapped, The Lancet,* Sept. 26, 1987, pp. 728-731.

ployee and the safety of the mentally retarded citizens in its care. Petitioners urge that review by this Court of the judgment of the Court of Appeals is appropriate for three reasons:

(1) The Court of Appeals' decision directly conflicts with applicable decisions of this Court enunciated in the "special needs" exception to the Fourth Amendment of the United States Constitution.

(2) A special needs exception to the warrant and probable cause requirement of the Fourth Amendment exists when a governmental agency requires mandatory blood testing for the detection of infectious, communicable diseases for the purpose to ensure the safety of employees and mentally retarded citizens in that agency's custody and care.

(3) The decision of the court below presents an issue "on which lower" courts widely differ.

I

THE DECISION BELOW CONFLICTS WITH THE SPECIAL NEEDS EXCEPTION TO THE FOURTH AMENDMENT OF THE UNITED STATES CONSTITUTION

The decision below imposes an unduly stringent standard upon Petitioners in order to justify the mandatory blood testing policy adopted for the purpose of ensuring a safe training and living environment for mentally retarded citizens whose care and custody is entrusted to Petitioner.

The Court below regarded the mandatory blood testing policy as an unreasonable search and seizure without applying the standards of the "special needs" exception to the Fourth Amendment of the United States Constitution.

The "special needs" exception to the Fourth Amendment has been enunciated by this Court in response to a recognition that, in certain circumstances, the usual probable cause and warrant requirements which are the underpinning of the normal need for law enforcement are not reasonable in certain governmental situations. When faced with a claim of a special needs, this Court has engaged in a balancing of the competing governmental and privacy interests to assess the practicality of the warrant and probable cause requirement.[6]

In succinctly addressing this special needs exception to the Fourth Amendment requirement that a search or seizure is not reasonable unless accomplished pursuant to a judicial warrant, this Court stated in *Skinner v. Railway Labor Executives Assoc.*, — U.S. —, 109 S.Ct. 1402 (1989) at 1414:

> We have recognized exceptions to this rule, however, "when 'special needs, beyond the normal need for law enforcement, make the warrant and probable-cause requirement impracticable.'" *Griffin v. Wisconsin*, 483 U.S. —, — (1987), quoting *New Jersey v. T.L.O.*, 469 U.S., at 351 (Blackmun, J., concurring in judgment). When faced with special needs, we have not hesitated to balance the governmental and privacy interests to assess the practicality of the warrant and probable

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[6] *Skinner v. Railway Labor Executives Assoc.*, — U.S. —, 109 S.Ct. 1402 (1989).

cause requirements in the particular context. See, e.g., *Griffin v. Wisconsin, supra,* at — — (search of probationer's home); *New York v. Burger,* 482 U.S. 691, 699-704 (1987) (search of premises of certain highly regulated businesses); *O'Connor v. Ortega,* 480 U.S., at 721-725 (work-related searches of employees' desks and offices); *New Jersey v. T.L.O.,* 469 U.S., at 337-42 (search of student's property by school officials); *Bell v. Wolfish,* 441 U.S. 520, 558-560 (1979) (body cavity searches of prison inmates).

The Government's interest in regulating the conduct of railroad employees to ensure safety, like its supervision of probationers or regulated industries, or its operation of a government office, school, or prison, "likewise presents 'special needs' beyond normal law enforcement that may justify departures from the usual warrant and probable-cause requirements." *Griffin v. Wisconsin,* 483 U.S., at —.

II

A SPECIAL NEEDS EXCEPTION TO THE WARRANT AND PROBABLE CAUSE REQUIREMENT OF THE FOURTH AMENDMENT EXISTS WHEN A GOVERNMENTAL AGENCY ENGAGES IN MANDATORY BLOOD TESTING FOR THE SAFETY OF ITS EMPLOYEES AND MENTALLY RETARDED CITIZENS ENTRUSTED TO ITS CARE

The governmental interest in regulating the conduct of railroad employees to ensure safety and the conduct of custom service employees to maintain the integrity of the United Customs Service to be drug free justifies a departure from the usual warrant and probable cause requirement.[7] Likewise, the governmental interest ensuring

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[7] *National Treasury Employees Union, et al. v. William Von Raab, Commissioner, United States Custom Service,* — U.S. —, 109 S.Ct. 1384 (1989).

a safe living and training environment for employees[8] and a safe living and training environment for mentally retarded citizens entrusted to the care of Petitioners[9] pre-

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[8] Not only are Petitioners' group homes and the group vocational centers licensed by the Department of Health, every regulation is designed to maximize the safety and welfare of the Petitioners' Community. For example:

004.09 Health of Personnel.

004.08A All employees shall have a pre-employment medical examination which shall consist of a physical examination by a physician. All persons shall have an annual tuberculin skin test except for those who have a positive reaction and are without x-ray evidence of active disease shall be required to have either chemoprophylaxis against tuberculosis infection or a chest x-ray every three years. Results of such examinations and tests shall be retained as part of the person's employment record.

004.08B Any person (including any volunteer) who is afflicted with a disease in a communicable stage, or who is a carrier of a communicable disease, or who has an open wound or sore, is not permitted to work in a capacity (including food service) where there is a likelihood of transmitting the disease or infection to a resident or to other personnel. (Ex. 124)

[9] The Petitioners' interest in the safety and well-being of mentally retarded persons entrusted into its custody for habilitation reflects the public policy of the State of Nebraska.

83-1,141. Mental retardation; policy; Department of Public Institutions; office of mental retardation; establish; advisory committee; appointment; cooperation with other departments. (1) It is hereby declared to be the public policy of the State of Nebraska that a pattern of facilities, programs, and services should be available to meet the needs of each mentally retarded person so that a mentally retarded person may have access to facilities, programs, and services best suited to such person throughout the life of the mentally retarded person. The complexities of mental retardation require a coordination of the facilities, programs, and services of the various agencies of the State of Nebraska and those of communities. Programs and facilities should be planned and provided as part of a continuum of service to mentally retarded persons.

sents a special need beyond the normal need of law enforcement.

Petitioners' interest in the amelioration of the historical plight of the mentally retarded and an affirmative governmental response to secure their reintegration into the fabric of society is also the public policy of the Federal Government. See: Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal & Scientific Interface,* 10 Creighton L.Rev. 124, 127-143 (1976).

Thus, the Federal Government has not only prohibited discrimination against the mentally retarded in federally funded programs, see § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, but it has also provided the retarded with the right to receive "appropriate treatment, services, and habilitation" in a setting that is "least restrictive of [their] personal liberty." Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 6010(1), (2). In addition, the Government has conditioned federal education funds on a State's assurance that retarded children will enjoy an education that, "to the maximum extent appropriate," is integrated with that of non-mentally retarded children. Education of the Handicapped Act, 20 U.S.C. § 1412(5)(B).

Certainly, the interest of Petitioners' in the safety and well-being of its employees and the mentally retarded citizens entrusted to its care is as important as the safety of the railways or the integrity of United States Customs Service.

The decisions below merit review because the Appeals Court's and the trial court's opinions disregard the special needs exception in both analysis and conclusion. The rationale adopted by the trial court and affirmed by the Appeals Court was the assessment of one factor—probability of transmission of the HIV and HBV virus.

Probable cause has been defined by this Court as ". . . a fluid concept—turning on the assessment of probabilities in particular factual contexts . . .". *Illinois v. Gates*, 462 U.S. 213, 232 (1983). By restricting its inquiry to the assessment of probabilities of transmission, both courts applied the improper legal standard of probable cause to determine whether or not Petitioners' mandatory testing policy was Constitutionally valid.

The fatal flaw of the Appeals Court and the trial court was in disregarding the necessity under the special needs exception to analyze the legitimate governmental interest at stake, but instead utilized a probable cause standard while ruminating over the probabilities of transmission of a communicable infectious disease.

The consequence of both courts' reliance on a probable cause standard for the risk of transmission as the determining test was to reject the balancing test of the special needs exception and elevate Petitioners' burden of proof to ensure the safety of employees and mentally retarded citizens to a level of proving actual infection in the mentally retarded population while ignoring the communicable and infectious nature of HBV and HIV; potential routes of transmission; past infection in the employee population; and the vulnerability of the mentally retarded.

Going no further in its analysis, the Appeals Court and the trial court failed to consider as required by the special needs exception whether the interference caused by the mandatory blood test was minimal given the employment context in which it takes place;[10] failed to analyze the privacy expectation of employees working for a governmental agency entrusted with the safety of its mentally retarded citizens; and failed to consider whether the Fourth Amendment protection is diminished because the mandatory blood testing policy was neither designed to enforce criminal charges nor likely to be used to bring criminal charges against the person investigated.[11]

By applying the standard warrant and probable cause requirement,[12] both courts applied an incorrect legal standard in holding that Petitioners' mandatory testing policy was unreasonable at its inception.

Clearly, this case is particularly well suited for ennunciating the principle that an exception to the normal law enforcement requirements of a warrant and probable cause to search exists when a governmental agency engages in mandatory blood testing for infectious, communicable diseases when it is done for the safety of its employees and those mentally retarded citizens entrusted to its care.

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10 After initial screening, testing will be done as part of an annual physical in which employees are already tested for tuberculosis, another infectious, communicable disease. (App., infra p. 34)

11 *O'Connor* v. *Ortega*, 480 U.S. 709 (1986)

12 *Payton* v. *New York*, 455 U.S. 573 (1980)

III

THE DECISION OF THE COURT BELOW PRESENTS AN ISSUE ON WHICH LOWER COURTS WIDELY DIFFER

Although this Court has recognized that the United States Constitution protects an individual's ilnterest in disclosing personal matters,[13] lower courts are widely divided both as to whether the Constitution establishes a right to privacy in information concerning medical conditions and the extent of that right.[14]

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13 *See, e.g., Carey v. Population Services International,* 431 U.S. 684, 685 (1977) (privacy right of autonomy in making decisions regarding contraception is founded in Fourteenth Amendment's guarantee of personal liberty); *Nixon v. Administrator of Gen'l Services,* 433 U.S. 425, 458 (1977) (privacy interest in protecting against disclosure of personal papers based, in part, on First Amendment freedom of political association); *Roe v. Wade,* 410 U.S. 113, 152-53 1973) (privacy right to make autonomous decision regarding procreation based on Fourteenth Amendment); *Stanley v. Georgia,* 394 U.S. 557 (1969) (individual right to read whatever one chooses in privacy of own home based on First Amendment); *Katz v. United States,* 389 U.S. 347, 350 (1967) (in dictum, noting that Fourth Amendment protects, in part, "individual privacy against certain kinds of governmental intrusion").

14 At least three courts have found such a right. *See, e.g., United States v. Westinghouse Elec. Co.,* 638 F.2d 570 (3d Cir. 1980) (privacy right in employees' medical files); *Caesar v. Mountanos,* 542 F.2d 1064 (9th Cir. 1976), *cert. denied,* 430 U.S. 954 (1977) (patients' privacy right in psychotherapist's patient files); *Hawaii Psychiatric Society, Dist. Branch v. Arivoshi,* 481 F.Supp. 1028 (D. Hawaii 1979) (same for psychiatrist's files). Some cases have alluded to, but have not specifically recognized, a constitutional privacy right in medical or other personal information. *See In re Zuniga,* 714 F.2d 632, 641 (6th Cir.) (noting only that if privacy right exists, it is not absolute), *cert. denied,* 464 U.S. 983 (1983); *General Motors Corp. v. Nat'l Dir. for Occupational Safety*

(Continued on following page)

To qualify for constitutional protection, the individual's expectation of privacy must be subjectively manifested and the expectation must be one that is reasonable and socially acceptable. *California v. Greenwood*, — U.S. —, 108 S.Ct. 1625 (1988).

Other federal courts continue to struggle with an emotionally charged issue which can often times overlook the constitutional perimeters of the right sought to be protected.

In the case of *Plowman v. United States Department of the Army*, 698 F.Supp. 627 (E.D.Va. 1988) plaintiff brought suit alleging nonconsensual HIV testing and disclosure of test results violated plaintiff's constitutional right to privacy. The District Court, addressing the privacy right stated at pages 633-4:

> In general, decisions recognizing a constitutional privacy interest refer to at least two categories of privacy: "[1] the individual interest in avoiding disclosure of personal matters, and . . . [2] the interest

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and Health, Dept. of Health, Education and Welfare, 636 F.2d 163 (6th Cir. 1980), *cert. denied*, 454 U.S. 877 (1981) (issue of constitutional privacy not reached because adequate safeguards were in place to protect against unwarranted disclosure of employees' medical files).

Other courts, however, have reached contrary results. *See Borucki v. Ryan*, 827 F.2d 836 (1st Cir. 1987) (no clearly established constitutional privacy right in preventing public disclosure of psychiatric evaluation) and *J.P. v. DeSanti*, 653 F.2d 1080, 1091 (6th Cir. 1981) ("not all rights of privacy or interests in nondisclosure of private information are of constitutional dimension"); *Taylor v. Best*, 746 F.2d 220, 225 (4th Cir. 1984) (court rejected prisoner's claim that disclosure of his family history to prison psychologist violated his constitutional privacy right).

in independence in making certain kinds of important decisions." *Whalen v. Roe,* 429 U.S. 589, 600-01, 97 S.Ct. 869, 876-77, 51 L.Ed.2d 64 (1977) (and cases cited therein). Plaintiff's claim in the instant case invokes constitutional protection under the first category. No controlling authority confirms the extension of the constitutional right in this category to medical information. There is authority supporting such a right; however, its scope is far from settled. Indeed, courts continue to struggle to define that right, often reaching contrary decisions. In these circumstances, one cannot fairly say that the nature of the alleged right was so clear that a reasonable official would have understood that anything Isbell did violated that right.

Three other recent cases support this conclusion. *See, e.g., United States v. City and County of San Francisco,* No. 84-7089 (N.D. Cal. Aug. 28, 1987) (unpublished opinion), *Local 1812, American Fed. of Gov't Employees v. United States Dept. of State,* 662 F.Supp. 50 (D.D.C. 1987) and *Leckelt v. Board of Commissioners of Hospital Dist. No. 1,* No. 86-4235 (E.D. La. Mar. 14, 1989) holding a hospital employer could test employees for HIV virus in order to make reasoned and medically sound employment decisions and in order to provide a safe workplace.

Although the court below recognized, "the district court did not take lightly, nor do we, the severe nature of the disease at which ENHSA's policy is aimed," App. infra at 28, both the Appeals Court and the trial court found that mandatory blood testing interfered with a broadly conceived privacy right that overrides the severity of HIV and HBV infection. App., infra at 18 & 26.

That rationale squarely conflicts with this Court's recent assessment of mandatory blood tests conflicting with a significant privacy interest.

> We said also that the intrusion occasioned by a blood test is not significant, since such "tests are common place in these days of periodic physical examinations and experience with them teaches that the quantity of blood extracted is minimal, and that for most people the procedure involves virtually no risk, trauma, or pain." Ibid. Schmerber thus confirmed "society's judgment that blood tests do not constitute an unduly extensive imposition on an individual's privacy and bodily integrity." *Winston v. Lee*, 470 U.S. at 726. See also *South Dakota v. Neville*, 459 U.S. 553, 563 (1983); *Skinner v. Railway Labor Executives*, op. cit. at p. 1417.

The Appeals Court's and trial court's blanket assertion that Petitioners' employees have a reasonable expectation of privacy under the Fourth and Fourteenth Amendments (without reference to whether or not a privacy interest in certain medical information exists) reflects the on-going effort to extend a right based on no definitive authority that a privacy interest in medical information exists.

Clearly, the constitutional issue of privacy in medical information is ripe for review by this Court. This case affords a clear opportunity to squarely address the issue of whether and to what extent a privacy interest exists in certain medical information.

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CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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Attorneys for Petitioners

May, 1989.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

PATRICIA ANN GLOVER, MICHAEL R. MACRANDER, SUSAN I. DAVIDSON, MARY ST. GEORGE, REBECCA A. DEMUTH, TIMOTHY SIKORA, DAPHNE HOLMES, SHAWNE A. KINSMAN, and DANIEL B. CHAMP, on behalf of themselves and all other persons similarly situated,

Plaintiffs,

v.

EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION, EASTERN NEBRASKA HUMAN SERVICES AGENCY, MICHAEL ALBERT, DONALD CLAASEN, RONALD HINELINE, RAY LIND, and HILTON ROGERS, in their capacities as members of the GOVERNING BOARD OF THE EASTERN NEBRASKA HUMAN SERVICES AGENCY, RAY CHRISTIANSON, in his official capacity as EXECUTIVE DIRECTOR OF THE NEBRASKA HUMAN SERVICES AGENCY, and DONALD MORAY, in his capacity as EXECUTIVE DIRECTOR OF THE EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION,

Defendants.

CV. 87-0-830

ORDER

(Filed March 29, 1988)

Pursuant to the memorandum opinion entered this date,

IT IS HEREBY ORDERED:

1) The defendants and each of them are permanently enjoined from implementing the Chronic Infectious Disease Policy No. 8.85, adopted by the governing board of the Eastern Nebraska Human Services Agency effective November 18, 1987, as amended January 20, 1988, to the extent said policy relates to the hepatitis B virus and the human immunodeficiency virus, and specifically from implementing the testing, reporting or disclosure requirements of said policy as to the hepatitis B virus and the human immunodeficiency virus.

2) The plaintiffs and each of them are exonerated from any liability on the bond on temporary restraining order filed herein and said bond is discharged.

3) Plaintiffs are granted until April 29, 1988, in which to file their applications for attorneys' fees, together with supporting affidavits and briefs. Defendants shall file their response on or before May 20, 1988. Hearing is set on any application for attorneys' fees for Monday, June 13, 1988, at 9 a.m.

DATED this 29th day of March, 1988.

BY THE COURT:

/s/ Lyle E. Strom
Chief Judge
United States District Court

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

PATRICIA ANN GLOVER, et al., Plaintiffs, v. EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION, et al., Defendants.	CV. 87-0-830 MEMORANDUM OPINION (Filed March 29, 1988)

This matter is before the Court for determination after trial to the Court. Jurisdiction of this Court is pursuant to 28 U.S.C. § 1331. Pursuant to Fed.R.Civ.P. 52, the Court sets forth the following findings of fact and conclusions of law.

The controversy in this case surrounds the Chronic Infectious Disease Policy No. 8.85 (the policy) adopted by the governing board of defendant Eastern Nebraska Human Services Agency (ENHSA) which requires certain employees to submit to mandatory testing for tuberculosis (TB), hepatitis B (HBV), and human immunodeficiency virus (HIV). The policy also contains a reporting requirement for employees who know or suspect they have any of the diseases and a disclosure requirement for employees who are hospitalized or receiving treatment for any of the diseases. This Court issued a temporary restraining order on December 7, 1987, restraining all testing for HIV and the reporting and disclosure require-

ments for all of the specified diseases. A revised policy was adopted on January 20, 1988, and it is the subject of this action.[1]

The plaintiffs in this class action suit consist of Patricia Ann Glover, Michael R. Macrander, Susan I. Davidson, Mary St. George, Rebecca A. Demuth, Timothy Sikora, Daphne Holmes, Shawne A. Kinsman, and Daniel B. Champ, on behalf of themselves and all other persons similarly situated. This action proceeds as a class action[2] with these named plaintiffs as proper class representatives, and the class is defined as:

> All current employees of the Eastern Nebraska Community Office of Retardation (ENCOR) employed in a position or job title identified in Eastern Nebraska Human Services Agency (ENHSA), chronic infectious disease personnel policy No. 8.85 effective date January 20, 1988, which positions are identified by policy 8.85 as home teacher, residential associate, residential assistant, vocational program manager, vocational production manager, registered nurse, and licensed practical nurse, and which positions or job titles are, pursuant to policy 8.85, subject to the ENHSA chronic infectious disease "testing requirement" (Par. II of ENHSA personnel policy 8.85) for human immunodeficiency virus (HIV) and hepatitis B (HBV), the ENHSA chronic infectious disease reporting requirement (Par. III(a) of ENHSA personnel policy 8.85) for HIV and HBV and the ENHSA chronic infectious disease "disclosure requirement" (Par. III(b) of ENHSA personnel policy 8.85) for HIB and HBV.

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[1] The plaintiffs have not challenged the policy as to tuberculosis, thus that disease is not at issue here.

[2] The parties stipulated in Paragraph D(16) of the pretrial order that this action should proceed as a class action as defined. The Court approved this stipulation at the pretrial conference on February 10, 1988.

The defendants in this action are: the Eastern Nebraska Community Office of Retardation (ENCOR); the Eastern Nebraska Human Services Agency (ENHSA); the members of the governing board of ENHSA, Michael Albert, Donald Claasen, Ronald Hineline, Ray Lind and Hilton Rogers; the Executive Director of ENHSA, Ray Christianson; and the Executive Director of ENCOR, Donald Moray.

The following facts may be accepted as established facts for the purposes of this case. The defendant ENHSA was established by Cass, Sarpy, Dodge, Washington, and Douglas Counties in Eastern Nebraska, and created pursuant to the Nebraska Interlocal Cooperation Act, Neb. Rev.Stat. § 23-2201, et seq. The defendant ENCOR is a part of ENHSA and is organized under Neb.Rev.Stat. § 83-1,141 through 83-1,146. ENCOR is subject to all of the rules and regulations of ENHSA including the chronic infectious disease policy (Personnel Policy and Procedures Manual—Policy No. 8.85 as adopted by the ENHSA governing board effective November 18, 1987, and revised on January 20, 1988).

The ENHSA governing board was created under authority granted by the Nebraska Interlocal Cooperation Act, and is comprised of one elected county commissioner from Dodge, Washington, Douglas, Sarpy and Cass Counties which make up Region VI under Neb.Rev.Stat. § 83-1,143.06. The members of the ENHSA governing board who adopted the policy are Michael Albert, Donald Claasen, Ronald Hineline, Ray Lind and Hilton Rogers, and are all county commissioners from each of the counties which make up Region VI.

The ENHSA governing board is responsible for: (a) governing and supervising the operation of ENHSA; (b) the appointment of ENHSA's Executive Director; (c) creation and enforcement of ENHSA rules; (d) the adoption of the annual budget; (e) establishing the amount of funds to be requested of each county; and (f) the general management of ENHSA. Funds for ENHSA and ENCOR are provided for by the federal government, the counties, and the State of Nebraska.

The policy in question requires employees in certain identified positions to submit to mandatory testing for tuberculosis (TB), the hepatitis B virus (HBV) and the human immunodeficiency virus (HIV or the AIDS virus), or be subjected to discipline for refusal to test.

The testing requirement will be applied annually if recommended by the agency's medical consultant to employees in the identified positions, and ENHSA reserves the right under the policy to require employees testing positive for TB, HBV or HIV to be tested more frequently than annually.

The policy also requires employees in the identified positions who know or suspect that they have a chronic infectious disease, as identified in the policy, to inform the ENCOR employee relations officer immediately. Failure to inform will result in disciplinary action which may include termination. [The reporting requirement, Policy, Par. III(a).]

The policy requires employees in the identified positions hospitalized or receiving treatment for a chronic infectious disease, as identified in the policy, to submit the

medical records relating to treatment for the disease to the ENCOR employee relations officer, if requested. [The disclosure requirement, Policy, Par. III(b)] Curtis Starks, the affirmative action director and employee relations officer at ENHSA, will have responsibility for notifying ENCOR employees in the identified positions of positive test results.

The Eastern Nebraska Community Office of Retardation (ENCOR), a sub agency of the Eastern Nebraska Human Services Agency (ENHSA) is a community based program which provides residential, vocational and other specialized services for the mentally retarded. ENCOR serves approximately six hundred clients who are mentally retarded, ranging from the mild to the profound level of retardation. ENCOR's client based foundation respects the individual rights of its clients, and the agency works diligently to insure that these rights are upheld on behalf of these clients. ENCOR's philosophy recognizes the dignity of risk, thus permitting its clients to live life with all its inherent risks, as they live in a community setting.

In this regard, ENCOR staff members receive training in numerous areas. For example, the staff members are taught behavior management skills and passive defense skills to enable them to deal with violent and/or aggressive clients in a non-abusive manner. Violent and aggressive behavior by the clients does exist at ENCOR. The evidence in this case shows numerous incidents involving biting, scratching, throwing of objects, hitting, violent outbursts, and pinching by the clients.

The testimony in this case establishes that the ENCOR staff is extremely capable of handling these be-

haviors through the various techniques they have learned at ENCOR. The passive defense techniques and behavior management training assist the staff in spotting potentially violent behavior and other behavior problems and protecting themselves from harm. The evidence demonstrates that the ENCOR staff is capable, caring and dedicated. The testimony of Frank Menolascino, M.D., is that the ENCOR staff is good to superior and that "precious few" of ENCOR's clients are found to be unmanageable, approximately three to five over a twenty-year year period. In addition, John McGee, Ph.D., stated that one of the "blessings" of ENCOR is its staff and that ENCOR is one of the top three programs in the country.

Extensive medical testimony was presented in this case concerning the human immunodeficiency virus or acquired immune deficiency syndrome (AIDS), hepatitis B, and other related matters. The human immunodeficiency virus is a retrovirus that attacks white blood cells (T-lymphocytes) in the human blood. This virus attacks the immune system and damages the ability of the infected person to fight off other diseases and the person then becomes susceptible to opportunistic infections.

Once infected with the virus, a person may show no signs of illness. Such a person does not have AIDS but is a carrier of the virus. Some of these infected persons go on to develop AIDS-related complex (ARC), a condition caused by the AIDS virus. Symptoms of ARC include weight loss, diarrhea, enlarged lymph nodes, and night sweats. As a result of the progession of the infec-

tion, "frank" or "full blown" AIDS can develop.[3] At this stage in the disease, the body's immune system is destructing and other diseases invade the body. These opportunistic infections, so called because they use the opportunity of the person's lowered resistance to invade the body, can and often do result in death.[4]

There is no known cure for AIDS, nor is there yet a vaccine to prevent it. Extensive research has been, and continues to be, conducted on the epidemiology of this disease to determine how it acts and is transmitted.

The medical evidence shows that the AIDS virus is present in semen, vaginal and cervical secretions, blood, breast milk and, in rare instances, tears and saliva. The primary routes of transmissions are via sexual contact with an infected person and by intravenous drug use, that is, by the sharing of hypodermic needles. The virus may also be transmitted by blood transfusions, across the placenta from mother to fetus, through mother's milk, and by prolonged exposure of broken skin to massive amounts of infected blood. Although the virus may be found in tears or saliva, no reported transmissions via these fluids have been reported.

In very rare instances, the virus has also been transmitted to health care workers through needle stick acci-

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[3] Medical science has not yet determined the time period of the progression of this disease from infection to full-blown AIDS. There are instances of HIV exposures which have not developed into AIDS. Medical science does not yet know if this is the result of a long incubation period or if these people will never get AIDS.

[4] Current statistics show that approximately 52,000 cases of "full blown" AIDS have been reported and 28,000 of these people have died from the disease.

dents and, even more rarely, through contact with massive quantities of infected materials. The medical evidence establishes that the AIDS virus is not transmitted by casual contact.[5]

Hepatitis B (HBV) is an infectious virus which is transmitted primarily by blood and sexual routes, not by casual contact. This virus is a much hardier than HIV, and there is a higher probability of infection from HBV than from HIV.

Unlike HIV, HBV is not a fatal disease, although there is mortality associated with the virus. Ninety-five per cent (95%) of those infected with HBV will fully recover. Of the remaining five per cent (5%), the disease will be fatal to ten to twenty per cent of these individuals, while the others will develop chronic hepatitis involving slow, gradual liver damage and will die some five to twenty-five years later from cirrhosis.

Also, unlike HIV, a highly effective immunization is available to control the spread of HBV. This immunization is recommended for health care workers by the Centers for Disease Control (CDC). Protection of unimmunized individuals who are exposed to HBV is available in the form of hepatitis B immune globulin. These two measures are available to ENCOR and are effective to prevent the spread of HBV.

ENCOR began its concern with the AIDS virus as a result of general publicity about the AIDS problem. Curtis Starks, the affirmative action director for ENHSA,

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[5] Casual contact includes, but is not limited to, touching, sneezing, coughing, breathing, handshakes, sharing of food or eating utensils, use of public toilets, sharing of drinking glasses, and the sharing of towels.

began to collect information on the disease. The majority of the information collected came from the Omaha World Herald and the U.S.A. Today newspapers.

In July of 1987, ENCOR's concern with AIDS became more acute when it learned that two clients from the Omaha Manor facility, a private facility that had recently closed, who were transferred to the Beatrice State Development Center, tested positive for the AIDS virus. Even though these clients were eventually found to not have the virus, the intense concern had taken root at ENCOR.

In September of 1987, an ENCOR employee, unrelated to the Omaha Manor incident, died from AIDS. At this point, the ENHSA governing board instructed Executive Director Donald Moray to develop a policy for mandatory AIDS testing of employees. The original policy was announced and challenged by the ENCOR employees. After this Court restrained the policy, and pending the trial on the merits, the policy was reviewed and some aspects were changed. The new policy, effective January 20, 1988, states that the persons holding or applying for the following titles must undergo testing: home teacher,[6] residential associate,[7] residential assistant,[8] vocational pro-

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[6] A home teacher provides a home environment to mentally retarded children or adults and is responsible for providing care and instruction to the client living in their home.

[7] A residential associate is responsible for the direct care and instruction of individuals receiving residential services and the monitoring and assisting in the care and upkeep of the residential facility.

[8] A residential assistant is responsible for the direct care and instruction of individuals receiving residential services.

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gram manager,[9] vocational production manager,[10] registered nurse,[11] and licensed practical nurse.[12] The policy also states that new positions may be added to the list. The rationale behind testing staff members in the identified positions is that these positions involve extensive contact with clients. The evidence in this case, however, shows that staff members who hold non-test positions have also been the recipients of bites and scratches from ENCOR clients.

The evidence shows that the ENCOR staff member who died from AIDS was involved in numerous incidents where he was bitten, scratched, pinched, kicked and hit by clients. When this staff member died from AIDS, how-

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This job includes providing services to clients and giving them the instruction necessary to be as independent as possible for activities which occur in their own lives.

9 A vocational program manager is responsible for preparing mentally retarded citizens for competitive employment and instructs clients in socialization, academics, communication skills, community access, self-management and work skills acquisition development.

10 A vocational production manager is responsible for production duties to insure realization of contract deadlines, quality control, efficient work flow, proper utilization of clients, training clients in work skills and shop maintenance and safety.

11 A registered nurse is responsible for coordination, consultation, training and monitoring of health related services to clients.

12 A licensed practical nurse is responsible for providing direct care to medically involved individuals receiving home based services. The licensed practical nurse attends to the health care needs of the clients and trains parents to meet these needs in the client's home.

ever, ENCOR did not follow up on the clients involved in any of these incidents, nor did they notify these clients or their guardians that ENCOR believed they were potentially at risk of contracting the AIDS virus because of the contact with this staff member.

There is some evidence of sexual abuse of clients at ENCOR. These incidents, however, are not limited to staff/client contacts, of which there are few reported incidents. The testimony of the ENCOR staff members, Executive Director Moray, and Deputy Director Brinker are all in agreement and establish that there is not a sexual abuse problem at ENCOR.

The AIDS virus may be detected by two medical tests, the enzyme-linked immunoassay test (ALISA) or the confirmatory test, the Western blot. Both of these tests are blood tests which determine the presence of antibodies to the AIDS virus.

The ELISA test is a simple blood test which can detect the presence of antibodies to HIV. A positive ELISA test, however, does not mean that a person has AIDS; it merely signifies that, if the tests results are accurate, the person has been exposed to the virus. A positive result on an ELISA test is not a finding that is reportable to the CDC for this positive finding is "not evidence of AIDS, but evidence of the agent of AIDS." (Testimony of Dr. Cox).

If the ELISA test is repeatedly reactive, the employee will be given the confirmatory Western blot examination. The confirmatory Western blot test is a more specific test which identifies antibodies to HIV antigens. The test, if positive for HIV, will show a pattern of distinctive

bands appearing at certain points on a paper strip which correspond to those bands on a strip associated with HIV. There is a lack of consensus among laboratories, however, as to the points on the bands that indicate the presence of HIV.

The ELISA test has a significant number of false positives. The Western blot is a more reliable test, with far fewer false positive results, yet they do occur. False positives occur as a result of laboratory error, either labeling errors or technical errors, previous illness, pregnancy, and because other retroviruses have the same molecular weight as the AIDS virus and can mimic a positive finding.

The State of Nebraska is a low prevalence area for the AIDS virus, that is, the amount of the disease in the State is low. As such, the predictive value of a positive result in any individual test is low, because the few positive test results that occur will contain some false positives. Thus, the percentage of false positives in a low prevalence community will be much higher than in a high prevalence community.

The medically indicated reasons for HIV testing are: (a) as an adjunct to the medical workup of a patient who may be infected, (b) for epidemiological purposes to establish the level of infection in a community, and (c) as a device used in conjunction with counseling those in high risk groups to stimulate them to change their high-risk behaviors. Testing in isolation as provided in ENCOR's policy does not serve these purposes.

The ELISA and Western blot tests are innocuous in themselves; however, the ramification of these tests gives

rise to serious problems. A positive report of an HIV test is a "very foreboding kind of message." (Testimony of Dr. Goldsmith). The reaction of patients to this news is devastation. If not handled properly, it can lead to disastrous results, including suicide. Because of the foreboding message that accompanies a positive HIV test result, some people simply do not want to know if they are infected.

In this case, the ENCOR employees who test positive would receive this devastating message from Curtis Starks, the affirmative action and employee relations officer at ENHSA. If Mr. Starks is unvailable, the personnel director will deliver the test result to employees. In addition, tested employees will not have the option of not being told of their test results.

There is no known cure for AIDS. Experimental studies are now under way searching for a cure for this disease. There has been some limited success with the drug AZT in treating the disease, but at this point, the disease is fatal. As such, major attention has been focused on controlling the spread of the disease. Until a cure is found, education about the prevention of the disease is the best available route to deal with AIDS.

Prevention of AIDS and controlling its spread is being effectuated, for example, by education regarding drug abuse and safe sexual practices, and by testing the blood supply at blood banks. In the health care environment, where certain workers are in contact with contaminated materials, policies have been adopted which limit the kinds of contact that are dangerous. Hospital workers take "universal precautions" on the job, for example, the

wearing of gloves when drawing blood and the wearing of gowns or other lab coverings when the clothing may be soiled by blood or other body fluids. Health care workers are also instructed as to the handling and disposal of needles to prevent accidental injury. It is procedures of this kind that are recommended by the CDC which has published recommendations and guidelines to help battle the spread of this disease. These recommendations and guidelines do not include, nor is there any evidence that health care workers, either generally or in select groups, are routinely screened for the presence of HIV. That these recommendations and guidelines are apparently effective is evidenced by the fact that health care workers, although theoretically at a higher risk than the general public, have few reported incidents of HIV transmission as a result of their jobs.

According to the Morbidity and Mortality Weekly Report (MMWR) of May 22, 1987, there have been five reports of HIV infection by non-needle stick exposure of health care workers who denied other risk factors. Two of these cases resulted from providing nursing care to HIV infected persons. These cases involved people who had daily, repeated contact with blood or body fluids of an infected patient over an extended period of time and who did not follow any routinely recommended barrier precautions.

Three additional health care workers have become infected with HIV following non-needle stick exposures to blood from infected patients. Two of these exposures involved prolonged contact with infected blood and with neither of the workers wearing gloves. The other expo-

sure was the result of a blood splatter, with blood splashing into the mouth of the health care worker. Considering the number of people who are infected with the AIDS virus and the numerous health care workers who are involved in their care, the fact that only five non-needle stick exposures to this disease exist, the Court believes, is remarkable in itself.

The evidence establishes that the risk of transmission of the AIDS virus from staff to client, assuming a staff member is infected with HIV, in the ENCOR environment is extremely low, approaching zero. The medical evidence is undisputed that the disease is not contracted by casual contact. The risk of transmission of the disease to clients as a result of a client biting or scratching a staff member, and potentially drawing blood, is extraordinarily low, also approaching zero. The risk of transmisison of the virus from staff to client due to the staff member attend ing to a client's personal hygiene needs is zero. Further, there is absolutely no evidence of drug use or needle sharing at ENCOR, nor is there a problem of sexual abuse of clients by staff.

In short, the evidence in this case establishes that the risk of transmission of the HIV virus at ENCOR is minuscule at best and will have little, if any, effect in preventing the spread of HIV or in protecting the clients. Further, from a medical viewpoint, this policy is not necessary to protect clients from and medical risks.

This case raises issues involving the Fourth Amendment rights of public employees. The Fourth Amendment to the United States Constitution protects the "right of the people to be secure in their persons, houses, papers,

and effects, against unreasonable searches and seizures . . . ," rights which are implicated only if the conduct at issue infringes "an expectation of privacy that society is prepared to consider reasonable." *O'Connor v. Ortega*, 107 S.Ct. 1492, 1497 (1987) (quoting *United States v. Jacobsen*, 466 U.S. 109, 113 (1984)). The Fourth Amendment is enforceable against the states through the Fourteenth amendment and seeks to "safeguard the privacy and security of individuals against arbitrary invasions by governmental officials." *McDonnell v. Hunter*, 809 F.2d 1302, 1305 (8th Cir. 1987) (*quoting Camara v. Municipal Court*, 387 U.S. 523, 528 (1967)).

Individuals have a reasonable expectation of privacy in the personal information their body fluids contain. Compulsory administration of a blood test "plainly involves the broadly conceived reach of a search and seizure under the Fourth Amendment." *Schmerber v. California*, 384 U.S. 757, 767 (1966). The mandatory testing required by the policy involves an involuntary intrusion into the body by the State for the purposes of withdrawing blood and constitutes a search and seizure for purposes of the Fourth Amendment. *Id.*[13] Having determined that the mandatory blood tests required by the policy constitutes a search and seizure, this Court must then determine whether the search meets the Fourth Amendment test of reasonableness.

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[13] There is no dispute and the Court finds that the defendants are state actors as both ENHSA and ENCOR were created pursuant to the Nebraska Interlocal Cooperation Act, Neb.Rev. Stat. § 23-2001, *et seq.*, and the governing board is comprised of one elected county commissioner from Dodge, Washington, Douglas, Sarpy, and Cass Counties who govern and supervise the operation of ENHSA. *McVarish v. Mid-Nebraska Comm. Mental Health Center*, 696 F.2d 69, 71 (8th Cir. 1982).

To determine the appropriate standard of reasonableness in this matter, this Court must balance the "nature and quality of the intrusion on the individual's Fourth Amendment interests against the importance of the government interests alleged to justify the intrusion. *O'Connor,* 107 S.Ct. at 1499, *citing United States v. Place,* 462 U.S. 696, 703 (1983); *Camara v. Municipal Court,* 387 U.S. 523, 536-37 (1967). In this matter, the Court must balance the ENCOR employees' reasonable expectations of privacy with ENCOR's interest in a safe training and living environment for all developmentally disabled persons receiving services from the agency.

That the AIDS "epidemic" is a matter of great concern to the public and to the government is a matter of common knowledge. The presently devastating character of this disease is frightening to everyone. It is in such circumstances that governmental units, the public, and most importantly, the courts, do not over-react and permit unreasonable invasions into a carefully formulated and preserved constitutional right as a response to this concern. Thus the Court is guided by the standard which requires that "both the inception and the scope of the intrusion must be reasonable." *O'Connor v. Ortega,* 107 S.Ct. at 1503. After careful consideration, the Court finds that the mandatory blood testing policy is not justified at its inception and constitutes an unreasonable search and seizure in violation of the Fourth Amendment to the United States Constitution.

ENHSA's justification for the testing is the pursuit of a safe work environment for all employees and a safe training and living environment for its clients. The medi-

cal evidence, however, demonstrates that even if staff members were infected with a chronic infectious disease, the risk to ENHSA's clients is extremely low and approaches zero. The medical evidence is overwhelming that the risk of transmission of the AIDS virus in the ENCOR work place is trivial to the point of non-existence. Such a theoretical risk does not justify a policy which interferes with the constitutional rights of the staff members.

Although the pursuit of a safe work environment for employees and a safe training and living environment for all clients is a worthy one, the policy does not reasonably serve that purpose. There is simply no real basis to be concerned that clients are at risk of contracting the AIDS virus at the work place. These clients are not in danger of contracting the AIDS virus from staff members and such an unreasonable fear cannot justify a policy which intrudes on staff members' constitutionally protected rights.

There was testimony in this case that there can be no guarantee that the ENCOR clients could not possibly contract the AIDS virus, and thus the policy is necessary because of the devastating consequences of the disease. This overly cautious, "better to be safe than sorry" approach, however, is impermissible as it infringes on the constitutional rights of the staff members to be free from unreasonable searches and seizures.

In addition, the mandatory testing of staff members is not an effective way to prevent the spread of the disease. This policy simply ignores the current state of medical knowledge which establishes that the AIDS virus is not contracted by casual contact. The defendants are

simply asking that this Court approve their policy because it is better to be safe than sorry. Donald Moray, the Executive Director of ENCOR, stated that his paramount concern was to "protect clients at all cost." This approach is impermissible for "at all cost" in this case includes the violation of the plaintiffs' constitutional rights.

The Court is convinced that the evidence, considered in its entirety, leads to the conclusion that the policy was prompted by concerns about the AIDS virus, formulated with little or erroneous medical knowledge, and is a constitutionally impermissible reaction to a devastating disease with no known cure. The risk of transmission of the disease from the staff to the clients at ENCOR is minuscule, trivial, extremely low, extraordinarily low, theoretical, and approaches zero. Such a risk does not justify the implementation of such a sweeping policy which ignores and violates the staff members' constitutional rights.

Likewise, the mandatory testing of staff members for HBV is not justified at its inception. There is no evidence in this case that the clients are at risk of contracting HBV from staff members. Even if there were evidence of such a risk, the policy would not be justified as other measures exist to promote ENCOR's interests in protecting its clients. Specifically, ENCOR could administer the HBV immunization to its clients, and be prepared to administer the hepatitis B immune globulin to an unimmunized client who was exposed to the disease. In addition, unlike testing, these measures are effective in preventing the spread of HBV and protecting the health of ENCOR's clients.

Accordingly, a separate order will be issued this date in conformity with this opinion enjoining the defendant

from implementing ENHSA policy 8.85, the chronic infectious disease policy, in regard to hepatitis B and human immunodeficiency virus.

DATED this 29th day of March, 1988.

BY THE COURT:

/s/ LYLE E. STROM
LYLE E. STROM, Chief Judge
United States District Court

ENHSA

PERSONAL POLICY AND PROCEDURES MANUAL

SUBJECT: CHRONIC INFECTIOUS DISEASE POLICY

POLICY NUMBER: 8.85

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 88-1678

Patricia Ann Glover; Michael R. Macrander; Susan I Davidson; Mary St. George; Rebecca A. Demuth; Timothy Sikora; Daphne Holmes; Shawne A. Kinsman; Daniel B. Champ, on behalf of themselves and all other persons similarly situated,	)	
Appellees,	)	
v.	)	
Eastern Nebraska Community Office of Retardation; Eastern Nebraska Human Services Agency; Michael Albert; Donald Claasen; Ronald Hineline; Ray Lind; Rogers Hilton, in their capacities as members of the Governing Board of the Eastern Nebraska Human Services Agency; Ray Christianson; Donald Moray,	)	Appeal from the United States District Court for the District of Nebraska.
Appellants,	)	
The American Public Health Association,	)	
Amicus Curiae.	)	

Submitted: December 12, 1988

Filed: February 6, 1989

Before HEANEY* and FAGG, Circuit Judges, and HANSON,** Senior District Judge.

FAGG, Circuit Judge.

This case concerns the validity of a Nebraska administrative agency's personnel policy requiring certain employees to submit to blood testing for the viruses associated with acquired immune deficiency syndrome (AIDS) and hepatitis B. In this class action brought by affected employees, the district court held the policy violated the employees' fourth amendment rights against unreasonable searches and seizures. *Glover v. Eastern Neb. Community Office of Retardation,* 686 F. Supp. 243, 251 (D. Neb. 1988). The court issued a corresponding order permanently enjoining implementation of the challenged portions of the policy. After carefully considering the district court's decision, we affirm.

Eastern Nebraska Human Services Agency (ENHSA) is a state agency dedicated to serving the needs of mentally retarded persons in Nebraska. Eastern Nebraska Community Office of Retardation (ENCOR) is a subagency of ENHSA covering a five-county area in the eastern part of the state. In response to a variety of events, ENHSA in 1987 adopted its Chronic Infectious Disease Policy No. 8.85. The policy, which applies to certain designated job descriptions, includes mandatory blood testing for the

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* The HONORABLE GERALD W. HEANEY assumed senior status on January 1, 1989.

** The HONORABLE WILLIAM C. HANSON, Senior United States District Judge for the Northern and Southern Districts of Iowa, sitting by designation.

AIDS and hepatitis B viruses. In addition to testing ,the policy requires employees to inform a personnel officer when they know or suspect they have one of the infectious diseases and to disclose medical records relating to treatment they receive for those diseases. Medical indications of the diseases or violation of the policy have employment consequences.

ENHSA's stated purpose for the policy is "the pursuit of a safe work environment for all employees and a safe training and living environment for all developmentally disabled persons receiving services from the [a]gency." The policy applies to job descriptions in which direct contact with clients occurs most frequently. The rationale for testing these employees is ENHSA's concern that clients who engage in violent or aggressive behavior associated with their conditions, such as biting and scratching, risk contracting one of the diseases from an infected employee.

After an initial court challenge, ENHSA revised the policy and readopted it in 1988. Several affected ENCOR employees then brought this class action, challenging the policy on a number of constitutional and statutory grounds.

During a trial to the court, the parties presented extensive evidence. This evidence included expert testimony on the following: the medical, psychological, and behavioral characteristics of the clients ENCOR serves; the training ENCOR employees receive; and the medical characteristics of the AIDS and hepatitis B viruses.

Based on this evidence, the court found:

> The evidence establishes that the risk of transmission of the AIDS virus from staff to client, assuming

> a staff member is infected with [the AIDS virus], in the ENCOR environment is extremely low, approaching zero. The medical evidence is undisputed that the disease is not contracted by casual contact. The risk of transmission of the disease to clients as a result of a client biting or scratching a staff member, and potentially drawing blood, is extraordinarily low, also approaching zero. The risk of transmission of the virus from staff to client dut to the staff member attending to a client's personal hygiene needs is zero. Further, there is absolutely no evidence of drug use or needle sharing at ENCOR, nor is there a problem of sexual abuse of clients by staff.
>
> In short, the evidence in this case establishes that the risk of transmission of the [AIDS] virus at ENCOR is minuscule at best and will have little, if any, effect in preventing the spread of [AIDS] or in protecting the clients. Further, from a medical viewpoint, this policy is not necessary to protect clients from any medical risks.
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> * * * *
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> * * * There [also] is no evidence in this case that the clients are at risk of contracting [the hepatitus B virus] from staff members.

Glover, 686 F. Supp. at 249, 251. Relying primarily on these findings, the district court concluded that under the fourth amendment, the mandatory blood testing policy was "not justified at its inception" for either the AIDS virus, *id.* at 250, or the hepatitis B virus, *id.* at 251. We agree.

Mandatory blood testing is a search and seizure that must comply with the standards of reasonableness imposed by the fourth amendment. *Schmerber v. California*, 384 U.S. 757, 767-68 (1966). The search's reasonableness is measured by " 'balanc[ing] the nature and quality of the

intrusion on the individual's [f]ourth [a]mendment interests against the importance of the governmental interests alleged to justify the intrusion.'" *O'Connor v. Ortega*, 480 U.S. 709, 719 (1986) (quoted citations omitted). ENHSA contended at oral argument that a lesser standard should apply because its clients are a particularly susceptible population. We believe, however, the district court correctly recognized that in this case, the Supreme Court standard requires us to balance the employees' reasonable expectations of privacy against ENHSA's interest in providing a safe training and living environment for its clients. *See Glover*, 686 F. Supp. at 250.

ENHSA bases its arguments on appeal primarily on a number of cases dealing with drug testing of persons subject to certain state-regulated environments. *See, e.g., Rushton v. Nebraska Pub. Power Dist.*, 844 F.2d 562 (8th Cir. 1988) (nuclear power plant employees); *Jones v. McKenzie*, 833 F.2d 335 (D.C. Cir. 1987) (school transportation employees), *petition for cert. filed*, 56 U.S.L.W. 3739 (U.S. Apr. 15, 1988) (No. 87-1706); *National Treasury Employees Union v. Van Raab*, 816 F.2d 170 (5th Cir. 1987) (customs employees), *cert. granted*, 108 S. Ct. 1072 (1988); *McDonnell v. Hunter*, 809 F.2d 1302 (8th Cir. 1987) (correctional institution employees); *Spence v. Farrier*, 807 F.2d 753 (8th Cir. 1986) (prison inmates); *Shoemaker v. Handel*, 795 F.2d 1136 (3d Cir.) (horse racing employees), *cert. denied*, 479 U.S. 986 (1986).

Relying on these cases, ENHSA argues the district court committed error in failing to: (1) recognize that the employees here work for a highly regulated state agency and, thus, have only a diminished expectation of privacy; (2) take into account the "strong and compelling" nature

of ENCOR's interest in protecting its mentally retarded clients; (3) analyze the blood testing policy as an administrative search; and (4) find the proposed testing procedures were reliable methods of detecting the diseases. We conclude each of these arguments, however, misses the mark in view of the factual findings made by the district court.

The district court found the risk that ENCOR clients will contract the AIDS virus from the employees is "miniscule, trivial, extremely low, extraordinarily low, theoretical, ad approaches zero." *Glover*, 686 F. Supp. at 251. The court made similar findings with regard to the hepatitis B virus. *Id.* We have carefully reviewed the record, and these findings are not clearly erroneous. *See* Fed. R. Civ. P. 52(a).

These critical findings also lead unmistakably to the conclusion that ENHSA's blood testing policy is not reasonable at its inception under applicable fourth amendment standards. Because the risk of disease transmission has been shown to be negligible in the ENCOR environment, ENHSA's articulated interest in requiring testing does not constitutionally justify requiring employees to submit to a test for the purpose of protecting the clients from an infected employee.

The district court did not take lightly, nor do we, the severe nature of the diseases at which ENHSA's policy is aimed. By our decision we intend no broad-based rule with regard to testing public employees for any infectious disease, including AIDS. We hold only that under the facts established in this case, the district court properly enjoined ENHSA's policy as an unreasonable search and

seizure under the fourth amendment. Finding no error of fact or law, we affirm the district court's decision.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

POLICY EFFECTIVE DATE: January 20, 1988
SUPERSEDES POLICY NUMBER: 8.85

(Effective November 18, 1987)

The primary intent of this policy is the pursuit of a safe work environment for all employees and a safe training and living environment for all developmentally disabled persons receiving services from the Agency. While a testing procedure for chronic infectious diseases will be required, its purpose is for early detection, medical diagnosis and medically supervised treatment. This policy is an extension of the Agency's current practice based on Rules and Regulations from the Nebraska Department of Health and the Nebraska Department of Social Services. The Agency will not supersede a physician's medical recommendations for an employee to return to work unless directed to do so by the Agency's Medical Consultant. The Agency will do its utmost to protect the confidentiality of

the employee at all stages of the testing and treatment procedures (refer to ENHSA Personnel Policy #8.10). The Agency is also committed to actively assisting employees who must undergo treatment for a chronic infectious disease. Chronic infectious diseases are identified as Hepatitis B, Tuberculosis and Human Immunodeficiency Virus and are not to be confused with or be equivalent to a contagious ailment such as the common cold or flu.

No person applying for or currently in a position identified in this policy, may work for the Agency while having an infectious or contagious disease. Those positions are currently identified as: Home Teacher, Residential Associate, Residential Assistant, Vocational Program Manager, Vocational Production Manager, Registered Nurse, Licensed Practical Nurse. New positions may be added to this list as identified.

I. NEW APPLICANT

A. Hiring Process: ENHSA Personnel Policy #1.00

1. Application/screening.
2. Interview.
3. Reference checks.
4. Pre-employment physical.
5. Job offer.

B. Pre-employment Physical

1. If a person is applying for a position identified in the policy, the pre-employment physical must be satisfactorily completed before the hiring process can be finalized.

a. The applicant will undergo test(s) specified by the Agency for chronic infectious diseases. In the case of a positive test result for Hepatitis B or HIV, a second verification test will be given.

b. The Agency will be responsible for cost of the test(s).

c. The Agency will share the results of the pre-employment physical with the applicant.

1) If the applicant is found to be free from a chronic infectious disease, the offer of employment will be made.

2) If the applicant is found to have a chronic infectious disease:

a) The applicant will not be offered employment at this time for these positions identified in this policy but may be considered for other positions with the Agency.

b) The Agency will provide information regarding medical and/or mental health services upon request of the applicant.

2. Upon successful treatment of the chronic infectious disease, the applicant may be reconsidered for a position covered by this policy with the Agency in accordance with ENHSA Personnel Policy #1.15.

a. Applicant shall authorize the provision of medical records/reports to the Employee Relations Officer of the Personnel Department verifying successful treatment of the chronic infectious disease.

b. The Personnel Department will review current openings for a similar position applicant initially applied for and refer the applicant to the hiring supervisor for an interview.

c. Upon a successful interview, the Personnel Department will make the job offer.

d. The Agency reserves the right to require the applicant, if hired for positions covered by this policy, to undergo test(s) for chronic infectious diseases on a more frequent basis than annually if recommended by the Agency's Medical Consultant.

II. CURRENT EMPLOYEE

A. Within two (2) weeks of the adoption of this policy, all current employees in positions identified in the policy statement will undergo test(s) for the chronic infectious diseases identified in this policy.

1. Employees who refuse to take the test(s) will be subject to disciplinary action which may include termination.

2. Employees who refuse to authorize the release of test(s) results to the Employee Relations Officer of the Personnel Department will be subject to Disciplinary Action which may include termination.

3. The employee may remain in his/her position while awaiting results of the test(s) unless conditions including, but not limited to the following, occur:

a. Suspension for disciplinary reason(s).

b. Approved vacation, sick leave or leave of absence.

4. Results of the test(s) will follow the same procedures as identified in Section "D", Results of Test.

B. Voluntary Testing

1. Voluntary testing for the Chronic Infectious Diseases identified in this policy will be available for all Agency staff upon request.

   a. All test(s) will be conducted at the Agency's medical testing facility.

   b. The Agency will be responsible for all costs of the test(s).

2. Results of volunteer testing will follow the same procedures as identified in Section "D", Results of Test.

C. Annual Testing

1. Annual testing will be conducted as part of annual physical for those employees in positions outlined in this policy. See ENHSA Personnel Policy #1.40.

   a. The Agency will be responsible for all costs of the test(s).

   b. Employees who refuse to take the annual physical will be subject to disciplinary action which may include termination.

   c. Employees who refuse to authorize the release of test(s) results to the Employee Relations Officer of the Personnel Department will be subject to Disciplinary Action which may include termination.

2. The employee may remain in his/her position while awaiting results of the test(s)

unless conditions, including but not limited to the following, occur:

a. Suspension for disciplinary reason(s).

b. Approved vacation, sick leave or leave of absence.

3. If the employee has a positive test(s) result(s) for a Chronic Infectious Disease covered by this policy, the Agency reserves the right to require the employee to be tested on a more frequent basis than annually if recommended by the Agency's Medical Consultant.

D. Results of Test(s)

1. The Agency will share the results of the test(s) with the employee.

2. If the employee is found to be free from chronic infectious disease, employment with the Agency will not be interrupted.

3. In the case of a positive test result for Hepatitis B or HIV, a second verification test will be given.

a. The employee will remain active in his or her current position until results of the verification test is received.

4. If the employee is found to have a chronic infectious disease after verification test(s):

a. The Agency will make every reasonable attempt to place the employee, or provide training for placement, into a position not identified in this policy.

b. If immediately unable to locate such a position, the employee will be removed from the identified position until a physician's release to return to that

identified position is provided to the Employee Relations Officer of the Personnel Department.

c. The Employee Relations Officer of the Personnel Department will notify the Office Director.

   1) The Agency will seek medical consultation to determine what precautionary measures need to be taken to insure the health and safety of clients.

   2) The Agency will keep confidential the identity of the employee.

   3) The Agency will insure and/all recommended Health Department precautionary procedures are actively utilized in the Area program where employee worked.

d. The Office Director will notify Governing Board of exposure and all pretionary procedures undertaken as a result.

e. The Employee Relations Officer of the Personnel Department will assist in arrangements for medical treatment of the disease if the employee so desires assistance.

   1) If the employee does not choose available treatment, he/she cannot comply with this policy for the identified positions and will be considered as an immediate quit. (Refer to ENHSA Personnel Policy #7.05.)

2) The employee may arrange for treatment from any medical facility of his/her choice.

3) The Personnel Department will assist the employee in locating a physician, medical facility or mental health provider to begin treatment if requested.

f. The employee must undergo available medical treatment for the disease before returning to work in an identified position.

1) Under no circumstances will the employee be allowed to return to the work place in a position identified in the policy statement until successful completion of medically prescribed treatment.

a) Procedures during treatment.

i) Accrued vacation and sick leave will be granted the employee while undergoing treatment.

ii) Other benefits will be granted where available and applicable.

iii) When Agency salary continuation benefits are exhausted, the employee will be terminated from employment. (Refer to ENHSA Personnel Policy #4.00.)

iv) The employee may, at his/her own expense, continue his/her health bene-

fits for a period of up to 18 months. (Refer to ENHSA Personnel Policy #4.20(e).)

v) The Agency reserves the right to fill the position left open by the employee after two (2) calendar weeks have expired, or sooner if client needs so warrant.

vi) The Agency will continue to make every reasonable attempt during this time to place the employee, or provide training for placement, into a position not identified in this policy.

2) If the employee is found to have a chronic infectious disease for which no medical treatment is available:

a) The Agency will make every reasonable attempt to place the employee, or provide training for placement, into a position not identified in this policy.

b) During the time in which the Agency is attempting to place the employee into a position not identified in his policy:

i) Accrued vacation and sick leave will be granted the employee.

ii) Other benefits will be granted where available and applicable.

iii) When Agency salary continuation benefits are exhausted, the employee will be terminated from employment. (Refer to ENHSA Personnel Policy #4.00.)

iv) The employee may, at his/her own expense, continue his/her health benefits for a period of up to 18 months. (Refer to ENHSA Personnel Policy #4.20(e).)

v) The Agency reserves the right to fill the position left open by the employee after two (2) calendar weeks have expired, or sooner if client needs so warrant.

3) Medical records/reports must be provided to the Employee Relations Officer of the Personnel Department concerning treatment for the chronic infectious disease and a physician's release to return to the work place.

a) The Agency will make every reasonable attempt to provide a similar position when the employee is released to return to work.

b) The employee will receive a salary not less than the sal-

ary received at the time when removed from the work place for medical treatment.

c) The Agency reserves the right to require the employee to be tested on a more frequent basis than annually if recommended by the Agency's Medical Consultant.

III. OTHER CONDITIONS FOR TESTING EMPLOYEES

A. Employee Exposure to Chronic Infectious Disease

1. An employee in the identified positions who knows or suspects they have a chronic infectious disease, as identified in this policy, must inform the Employee Relations Officer immediately. Failure to inform the officer will result in Disciplinary Action which may include termination. The Employee Relations Officer will arrange with the employee for testing to be given for chronic infectious disease as outlined in this policy.

2. Procedures will then coincide with II, D.

B. Hospitalization for Chronic Infectious Disease

1. If an employee in the identified positions is hospitalized or receiving medical treatment for a chronic infectious disease as identified in the policy statement, the medical reports relating to the treatment of the disease must be submitted to the Employee Relations Officer of the Personnel Department if requested.

2. Procedures will then coincide with II, D.

DEFENDANT'S EXHIBIT 105

ENHSA PERSONNEL POLICY AND PROCEDURES MANUAL

SUBJECT: EMPLOYMENT PHYSICALS

POLICY NO.: 1.40

POLICY EFFECTIVE DATE: January 20, 1988

SUPERCEDES POLICY NO.: 1.40 (Nov. 1, 1987)

ENHSA has established set physical procedures to insure that employees meet State licensing requirements and standards set by State Health and Public Welfare Departments as well as the Agency's Chronic Infectious Disease Policy.

a) All ENCOR, MAINTENANCE and TRANSPORTATION applicants must receive a pre-employment physical. No applicant, for any position within ENCOR, Maintenance, and/or Transportation, will be hired until a physical examination has been conducted and the results of that examination returned to the Personnel Office.

   MAINTENANCE, TRANSPORTATION, and ENCOR RESIDENTIAL/VOCATIONAL STAFF that work with clients more than half of their time need annual physicals. ENCOR positions included in this paragraph are specifically identified in Personnel Policy #8.85.

b) The Pre-Employment and/or Annual Physicals for all ENCOR applicants and staff for those positions identified in Personnel Policy #8.85 *will include* tests for Hepatitis B, and Human Immunodeficiency Virus.

c) ENCOMH staff in the Youth and Family Services Division spending 20% or more of their time in direct client services must receive a pre-employment physical as well as an annual physical.

d) Employees who work in ENOA or ENHSA administration (with the exception of Transportation

and Maintenance Department) are not required to have pre-employment or annual physicals unless requested by the Office Director or Executive Director.

ENCOR staff who provide direct client services, ENCOMH staff who need physical examinations as stipulated in paragraph (C) and Transportation and Maintenance staff, must be able to safely lift a minimum of seventy (70) pounds. In addition, those individuals who may suffer from seizures or "blackouts" of any kind must not have suffered from such a "blackout" or seizure during the twelve (12) months immediately preceding their date of hire.

In accordance with State Health Department regulations and the Agency's Chronic Infectious Disease Policy, employees found to have a communicable disease shall be removed from their work place and may not return until released by a physician. Also, an employee who experiences a seizure or "blackout" of any kind, or receives an injury that precludes them from meeting the lifting requirement, will be removed from their work place and may not return until released by a physician.

Any ENHSA applicant required to have a pre-employment physical, must do so on his/her own time. However, annual physicals may be taken during work hours.

All Pre-employment and Annual physicals will be conducted at the Creighton Family Practice Clinic located in St. Joseph's Hospital, 601 No. 30th, Room 4710. To set up an appointment at the Creighton Clinic, the employee must call 280-4170 and identify themselves as an ENHSA employee. Physical examination forms will be supplied at Creighton Family Practice Clinic. All physicals will in-

clude a TB test. The TB record card must be completed in 2-3 days after receiving the test and returned to Creighton. IF THE TB CARD IS NOT RETURNED PROMPTLY, A RE-TEST WILL BE REQUIRED.

EXCERPTS FROM THE TESTIMONY OF DR. MENOLASCINO

(p. 610:8-19) Q. Are you aware or familiar as to the number of allied medical problems that the ENCOR clients have?

A. Uh-huh.

Q. And how many clients have allied medical problems?

A. I did a study for a presentation that I'm going to be giving in Holland in March. The incidence of associated medical needs of ENCOR clients, looking at a total, the time span of this was 1976 to 1986, the study was completed a year ago and I've had a year to analyze. A total in of 616 at that time. That was the most common number of clients in ENCOR and of those, 208 had associated medical needs. The most common one, far and away, were seizure phenomena.

* * *

(p. 613:14-25) Q. Doctor, are there any medical consequences of the 208 clients that have allied medical problems that you described and also those 100 that also have major mental illness?

A. Yes, there are.

Q. What are those and would you discuss those, please?

A. The consequences—and I mentioned some already. For example, of the 84 who also have major epileptic, convulsive disorders, they tend to be on anticonvulsant medication. As I mentioned, these tend to be toxic—agents

that have to be carefully monitored as far as blood levels, monitored as far as any depression of the bone (p. 614: 1-25) marrow.

Chronic otitis media, another one that I mentioned, here again can be a long-term infection which literally wears the individual down. They may be on medication repeatedly, two or three courses of antibiotics and different variations of that.

Diabetes mellitus by its very nature can present a major problem in regards to, one, keeping the person in metabolic balance; secondly, there is always the danger of coma in a diabetic; thirdly, diabetic individuals are more prone to infections, especially in the peripheral parts of the body—the hands and the feet.

So there are medical components there of management itself, how much insulin is needed, type of insulin or insulin responses.

And lastly, hypothyroidism, which I mentioned was in 16 of these individuals. Hypothyroidism, by its very definition, makes a person more prone to infection; makes a person have major problems as far as metabolic slowing, and this is not only seen, for example, in the skin where the skin turgor is very dull-like instead of flexible, a person tends to be highly constipated which also disrupts problems of metabolism; proneness to infection; actually delayed growth. These individuals present some major medical problems; for example, have to be on thyroid for the bulk (p. 615:1-23) of their lives.

Q. Doctor, does ENCOR also—I believe you testified today they have 85 individuals who have Down's Syndrome?

A. I didn't testify but they do have 85 with Down's Syndrome.

Q. Would you describe that, what that means, Doctor?

A. Yes. Down's Syndrome was first described in 1866 by Sir Langon Down and today is known to have about 116 different clinical signs and symptoms, and these range from signs and symptoms in the hands; distinctive fingerprints; small, almond-shaped eyes slanted downwards; the fold of the eye is different; the structure of the oral cavity is different; the tongue tends to be large; the sinuses tend to be small.

They tend to have major defects of many organ systems; for example, 16 per cent of Down's Syndrome children will also have a major cardiac anomaly, and the number of problems they have in regards to gross physical are also mirrored in regards to hypothyroidism, which is quite high in Down's Syndrome; immunological deficiencies, especially the beta gamma globulin system. Also in regards to problems in response to infection, response to seizure phenomena, so the internal milieu, the internal body component of the Down's Syndrome individual presents some major problems.

(p. 616:16-24) Q. What does that mean, Doctor?

A. That means actually the immunological defense system is actually impaired in Down's Syndrome, which is one of the first lines of defense in the body. Beyond that, on a clinical basis, Down's Syndrome individuals from the very beginning of their description have been known to

be highly prone to upper respiratory and lung, pneumonia, processes.

* * *

(p. 618:4-12) So present chronic infection in Down's Syndrome, present immunological kinds of problems make them far more at risk as far as the handling of infection of any kind; also, in regards to just body integrity. For example, usually the Down's Syndrome individual also has a very light skin, vessels are very close to the surface, they tend to hyper-react in regards to an allergic phenomena, to drugs, for example, prescription drugs you may give these individuals, they tend to get in to the abnormality of the immunological system.

* * *

(p. 621:7-25) Q. What are the consequences for those individuals that have the impaired or reduced immune systems in the ENCOR community?

A. The consequence is that they are more prone then, because of a compromising immunological system, to infection of any kind, and in particular any kind of infection which would directly impact the blood system or the immunological system itself. They would be—they would really have a compromised immunological system.

Q. Other than being more prone to catching an infection, what happens to those impaired individuals when they catch the infection?

A. In the Down's Syndrome, they don't handle it as well in regards to basic lines of defense in the body, in regards to the blood system, the immunological system, in regards to, as I mentioned earlier, even the basic blood

dynamics—there's impaired heart, there's sinuses being different as far as aeration of the air. So they actually tend to have more refractive infections to treat and more (p. 622:1) prolonged, if you will, chronic infections.

* * *

EXCERPTS FORM THE TESTIMONY OF DR. JOHN McGEE

(p. 677:15-25) Q. I think you have answered part of my complex question and that is in regard to the residual complex and their behavior. But regard to those mentally retarded citizens that have already been deinstitutionalized, is there generally still behavior problems that have been associated with their institutionalization or their mental retardation that are still exhibiting themselves, even though they have been brought into community-based programs?

A. No doubt about it. Some people used to think, and some people still do, that the mere process of getting people out of institutions would totally transform and ameliorate (p. 678:1-25) each and every person. That does happen with some, the ones whom I mentioned earlier.

The fact of the matter is it doesn't happen for all people. There are some people who have behaviors that are so entrenched that it takes weeks, months, years even, to ameliorate those particular behaviors.

Also, you have to add onto that that people with mental retardation are fully human, just as you and I are, and just as we can have good days and bad days, so, too, do people with mental retardation. So someone may be going along quite well and then, for any number of reasons, they can regress and their risk for regressing is greater than ours, again for other reasons that I could explain later, if you would want.

But there's no magic bullet. The mere act of deinstitutionalization does not generally ameliorate behavioral conditions. It increases the probability that they can be ameliorated. But even with that, there are others with mental retardation who, because of the nature of the retardation or the learned patterns and the history of the behavior problems, that those take a while to deal with.

Q. When you say "a while," are you talking in terms of weeks, months, years?

A. I'm talking of any segment of time you want to choose. With some, it can be hours. With others, days or (p. 679:1-8) weeks. With some few, months. And with few still, years. Even then if you do ameliorate the condition today for Johnny, that doesn't say anything about six months from now that there will not be regression because maybe their mother dies, they can't express themselves, they can't reach out to other people like you and I do, so they could express their sorrow, their anger, their frustration through what we call aggressive or self-injurious behaviors.

* * *

(p. 685:20-25) Q. Doctor, do you know how many—since 1972, approximately how many ENCOR clients you have worked with?

A. I would say at least 300.

Q. And that would be on a direct basis?

A. On a direct personal basis.

Q. And are you currently familiar with the demographics (p. 686:1-25) of the client population at ENCOR, Doctor?

A. Yes.

Q. What is your understanding as to the breakdown as to those individuals with moderate, profound, severe and mild retardation?

A. I think there's about 207 with mild mental retardation; around 240 with moderate mental retardation, and the rest are people with severe to profound mental retardation, about 116 with severe mental retardation and another 41, I believe, with profound mental retardation.

Q. The ENCOR clients that you see that are dual diagnosis, do they range the complete gamut of the four categories of mental retardation?

A. Yes, they do.

Q. Doctor, are you also involved in the training of clients and/or staff presently at ENHSA?

A. Yes, I am.

Q. Would you briefly tell us what type of training you do for staff at ENHSA?

A. As of, I believe it was, November the 18th, we have a small—the Creighton University has a small contract with the Eastern Nebraska Human Services Agency to—in the ENCOR facilities themselves to work with clients with the most disruptive behaviors, as well as the direct care-givers involved with them, in order to focus on what we consider to (p. 687:1-15) be new and better ways of dealing with those behaviors.

Q. If I understand what you are telling me, you train staff by working with the clients, would that be a fair statement?

A. Yeah. We found out the hard way many years ago that people with mental retardation or anybody with severe behavior problems aren't like cars, where you just take them in to get fixed, which is in the beginning the way we dealt with severe behavior problems.

The issue quickly becomes clear that dealing with a person with, say, severe head-banging, severe aggression, severe withdrawal, the only real realistic way you can deal with it is by working both with that particular person and his or her care-giver because all—all learning is a relationship between let's call him the teacher, the care-giver, and the client or the student.

* * *

(p. 701:16-25) Q. Doctor, over the years have you worked with clients that have at times appeared to have improve as far as their aggressive behavior with regard to biting and then would regress and go back and display more aggressive behavior in the form of biting or scratching?

A. Yes, I have.

Q. Is that not uncommon with the mentally retarded individual or with some mentally retarded individuals?

A. It's very common for all human beings to—to progress and sometimes regress, depending upon what's going on in their (p. 702:1-19) life. The misconception that people have is that there is a magic bullet that if a person has either a mental illness or a severe pattern of, say, biting or

scratching, that all that you have to do is "X" and then that behavioral problem disappears.

In practice, what happens, there is a technology and there are values that can lead us to reduce dramatically the behavior problems that the people engage in. That, however, because they are human and we are human, does not validate any conclusion as to say once somebody has stopped biting, this year, that next year they won't do it again. There is no magic solution to it. And as sad as that seems, it also has a good side from the perspective that the people that we are talking about, people with mental retardation, are full human beings and are subjected to the same frustrations and stresses and anxieties, and even though they can't respond to them oftentimes as we might want them to, they're still subjected to them, and so it actually goes to their full sentient nature.

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(p. 703:2-18) Q. Doctor, there has been some suggestion by the plaintiffs that some type of educational program should be instituted for the clients at ENCOR to try to educate them as to either the modes of transmission of HIV or as to sanitary precautions to take in case there is some type of blood spillage. Based upon your knowledge of the clients at ENCOR and your working knowledge of the mentally retarded citizens, would in fact it be feasible to try and institute some type of educational program along that line for the clients of ENCOR?

A. Well, I always think it's laudable to engage in educational programs but you have to be realistic. Many of the people whom we are talking about cannot read or

write. Many of them cannot hear. Many of them cannot talk. So to say that, quote, an educational program to teach them about the dangers of AIDS or any other communicable disease essentially borders on the ridiculous.

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EXCERPTS FROM THE TESTIMONY OF DR. COX

(p. 788:5-25) Q. What are those aspects, Doctor?

A. To me the aspects that I discussed include the facts that the ENCOR clients are mildly to moderately to severely retarded individuals who have varying capabilities of responding and understanding the problems of every-day life and living and existence. Also, that these clients, and I am not an expert in the classification of retardation, but in my general medical training and otherwise, many significantly retarded individuals have a considerable degree of emotionability, they exhibit greater or lesser degrees of aggressive behavior at times requiring medication, at times requiring physical restraint in order to prevent them doing injury to themselves or to others.

With the increased incidence of aggressive behavior, physical contact between clients and staff, there are bound to be injuries from time to time. The transmission of a contagious disease or an infectious agent leading to transmission of disease from one individual to another generally requires that the natural mechanical defenses of the recipient be damaged. One of our major defenses against infectious disease is the intact skin. Once skin is not intact due to (p. 789:1-25) an abrasion, laceration, biting or blows of any kind, agents can penetrate in the area of the broken skin.

Similarly, the mucous membranes lining the eyes, the nose, the mouth, the intestinal tract and the respiratory tract—the lungs, trachea et cetera—tends to be more permeable to infectious agents. There are other defensive mechanisms in place there: the impact mucosa, the cilia or

the little tiny processes on the cells in the respiratory tract that keeps sweeping things back out; the motion of intestines that keeps things moving so that organisms don't stick; and breaks in the mucosa for any reason, such as the gums, the lips, anywhere in the mouth—it could happen by a physical blow on the mouth, the teeth producing a lesion in the mucosa, or just when you bite your tongue, bite your cheek, bite down on a bone, if somebody is being fed and may have any force using a spoon, that could break the mucosa, and whenever there are breaks in the mucosa the people would be more subject to the transfer of an infectious agent.

Similarly, a good deal of the defense across the mucosa is involved with immune products made by the body that tend to neutralize agents crossing the mucosa, the so-called IGA or it's one of the immunoglobulins or an antibody that is formed that is specifically Xed on mucosal surfaces to bar many agents crossing.

A significant number of retarded persons have (p. 790:1-25) associated damage to their immune systems and anybody with a damaged or somewhat defective immune system is more liable to have an infectious agent transferred from outside their body, across their mucosal surfaces so that it gets into the body where it can begin to infect or grow.

Similarly, once it has penetrated, as I pointed out earlier, the immune system within the body is a significant defensive mechanism and tends to develop and destroy that organism as it begins to multiply and, in most cases, wipe it out, and that is probably true even of HIV. When it first penetrates into the body, there are various immune

mechanisms that prevent it from becoming established. Once it becomes established and incorporated in the DNA, there's not a hell of a lot you can do about it.

So people with a defective immune system are not only more likely to get it transferred through the mechanical barrier of the mucosa into the system but it is more likely to get established once it gets there and develops a chronic infection with it.

So the clients of ENCOR, in my opinion, are very likely to have or to inflict breaks in the skin on staff members or on themselves, and if the staff member is positive with HIV, if the staff member bleeds from damage that is produced in physical contact with a client, that blood is presumably infectious for HIV virus or for HBV virus and (p. 791:1-25) can be transferred to that client.

If the client has bitten and gets blood in its mouth, he may have damaged the gums or something in the process and the blood that is positive for HIV may then be able to penetrate the mucosa in the mouth or through breaks in the mucosa in the mouth and become established, especially if there is a defect in the immune system that contributes.

If in the tussle or the physical contact between the client and the staff member physical breaks of the skin are occurred in both individuals, blood may be transferred from one skin break to the other. It may be taken and transferred from a skin break in the staff member who is infected and rubbed in the eye or on the mucosal surface of that client.

And the three cases reported by the Centers for Disease Control in the May 17th MMWR are examples,

apparently well documented, or small amounts of blood contamination from an infected individual producing infection in somebody who was exposed.

One of these cases involved getting blood on the hands and probably rubbing it in an area of dermatitis in the ear.

Another involved just getting some blood on a chapped or with a hand with dermatitis, getting a few drops of blood on, and that health care worker converted a few weeks (p. 792:1-8) later to HIV positivity.

So there is evidence that of the 50,000 cases of AIDS in this country, CDC has come up with at least three cases that appear where very small amounts of blood transferred from an individual positive for HIV antibody, transferred to the mucous membranes or a non-intact skin surface of another individual, has led to infection—transmission of an infectious agent and ultimate potential for disease in that individual.

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EXCERPTS FROM TESTIMONY OF DR. BROOKS JACKSON

(p. 889:20-25) Q. Have you performed any studies in reference to testing or accuracy of testing of the Western blot?

A. Yes, we have and I will be—I should mention that these results,I will be testifying before the Presidential Commission on the Human Immunodeficiency Virus Epidemic next Tuesday. I will be glad to give you those (p. 890:1-25) results now, if you would like. We have been involved in a study evaluating the risk of false-positives in a low-risk population, such as blood donors, and to be more specific, three blood centers, including the Red Cross in Minnesota, between March of 1985 and September of 1987 some 580,000 blood donors or blood donations were screened for HIV antibody.

THE COURT: You say five hundred and eighty?

THE WITNESS: Five hundred and eighty thousand.

A. And that is from, though, 250,000 different blood donors because blood donors can be repeat donors. Some of those donors may give more than once. But 580,000 donations from 250,000 different Minnesota blood donors. We found that there were 15 HIV antibody positive individuals, that is, positive by the ELISA and the Western blot.

To see if there were any false-positives among those 15, we worked with the State Department of Health in Minnesota to recall those blood donors and we were able to recall 13 of the 15 blood donors and we were able to redraw

blood from those patients and we were able to culture virus from all 13 of those patients. They were also, I should say, Western blot positive as well, all 13 of them, and several of them actually could detect viral protein directly in their blood.

The other two individuals that we could not—that (p. 891:1-15) did not wish to participate in this study however did admit to being in high-risk groups. One was a male and one was a woman, a sexual partner of an i.v. drug user and she in fact had symptoms of HIV infection. So, you know, given those histories and given that we were able to isolate or culture virus, HIV, from all 13 blood donors that participated, I feel we had no false-positives whatsoever in screening 580,000 donations from 250,000 different blood donors.

And blood donors, you must realize, are an extremely low-risk population, and these people before they donate blood have, you know, been screened for risk factors. They are asked whether, you know, they are in high-risk groups such as i.v. drug abusers or gay males or, oh, you know, whether they have been in high-prevalence areas such as Africa or Haiti, this sort of thing.

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(p. 892:1-19) Q. So, Doctor, the study that you performed of 250,000 blood donors, the results were, as I understand your testimony, no false-positives of that study of approximately 600,000 donations of blood?

A. That's correct.

Q. How does that compare to the false-positive rate for Western blot by the Department of Defense for their mandatory screening program?

A. Dr. Donald Burke, who is in charge of HIV antibody screening of military recruits, has reported that he had one false-positive in 135,000 Army recruits. Like I said, ours was certainly less than one in 250,000 blood donors and 580,000 blood donations. The risk, it's very, very small and certainly less than one in 100,000. I feel very comfortable with the accuracy of this test in that the risk of false-positives is extremely low. I would feel very comfortable having this test performed on myself and I have had it five or six times, as well as everybody in our AIDS Treatment Unit and Laboratory have.

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(p. 895:3-6; 11-23) Q. Would you describe what the Western blot test is and procedures utilized and the criteria that your lab will utilize in analyzing, say, the ENCOR specimens if we ever come to that stage?

* * *

A. If we were to receive a specimen from Dr. Cox' lab, for instance, it just comes with a number. We have no identification by patient name or anything. It's a serum sample and we would perform an EIA test on that.

Q. How big is that serum sample you receive?

A. Well, in order to perform these antibody tests, you only need one sample, one sample to do the EIA, the Western blot, all the confirmatory assays, you only need one sample of blood, and it's about seven milliliters of blood, which is the equivalent to about—if you think of—it's about one-quarter of an ounce or so, so it's, you know, about one quarter or one fifth if it's in a shot glass or something like that, not very much blood.

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(p: 896:6-25) A. So it's not much blood, and we can do all those tests on just that one sample for antibodies.

Now, we would do the EIA again and we would do the Western blot, and do you want me to describe the Western blot, how it is done, briefly?

Q. Yes.

A. The Western blot is a test that detects antibodies similar to the ELISA. It's the same in principle. The only difference really is that one takes the viral proteins and separates them out on a gel by electrophoresis and then transfers it to a piece of paper and then cuts the paper into strips, and on each strip you have separated the viral proteins along the strip, and so one just takes this strip of paper and takes some of the sample from the patient, the serum, and puts it in a tube, so you've got the strip and you've got the blood in the tube, and they just kind of rock back and forth overnight, and if there's antibody to the viral proteins, it will attach to those spots on the paper where there are viral proteins.

Then one washes it and then adds a goat, anti-human,

* * *

(p. 898:1-11) characteristic viral protein that one sees on these strips and there is a diagram showing the anatomy of the virus and what—which bands correspond to which viral proteins.

Q. Are there different viral proteins in different bands?

A. That—yes, there are. Typically on a Western blot one may see as many as nine viral bands which correspond

to viral proteins. These viral proteins represent different parts of the virus. Three of them might be the proteins of the core of the virus. There are another three that represent the envelope, the coating of the virus, and there are another three that represent the enzyme proteins of the virus.

* * *

(p. 901:12-24) So we perform this assay and if we see this characteristic band pattern which we difine as a positive, as the presence of at least one glyco protein, which is the envelope proteins, the 41, 120, and 160, and at least one other band, so we want at least two-characteristic viral bands and in reality one rarely ever sees just two, one almost always sees at least five, but in looking at the large number of AIDS patients and HIV-infected patients as documented by cultures or antigen in their blood, the presence of a glyco protein plus one other band is always there on those blots, and that's why we feel very confident in using that criteria in calling something positive, and it is really the same criteria that the Centers for Disease Control use as well.

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(p. 905:15-25) Q. Doctor, based upon your experience and education, your actual testing methodology and criteria, do you have an opinion as to the probability of a false-positive emanating from the performance of a Western blot to the HIV virus?

A. Well, judging from our data on the blood donors, which is a very low-risk population and which, if you were going to get false-positives, that would be the population you are most likely to get false-positives, I would think that in screening the employees at ENCOR that it would

be the same or less than the risk of a false-positive in our blood-donor population, which is at least less than one in (p. 905:1-7) 250,000. So I think it is extremely—extremely low.

Q. Is it your opinion that the test is a reliable accurate scientific tool for the detection of the HIV antibody?

A. Yes, it is. It is accurate. The risk of false-positives is extremely low. It is reliable, HIV antibody, I believe it's a reliable indicator or not just HIV antibody but also HIV infection. It's a simple test to perform.

* * *

(p. 908:13-18; 21-22) Q. Have you formed any opinion based upon your review of the items which you just mentioned, the exhibits, and also based upon your professional training, concerning the risk of transmission of HIV from staff to client assuming that the staff person is infected?

A. Assuming that they're infected?

* * *

A. Yes.

Q. Okay. And what is that opinion?

* * *

(p. 909:6-25) A. My opinion is that given the incident described in Exhibit 34 and Exhibit 134, I believe there is a risk of transmission if that person were infected. I believe there is a risk because there have been at least fifteen reported or documented HIV transmissions in the literature that involved similar incidents such as described in these reports. Of those fifteen incidents that I refer to, nine have been needle sticks, involved needle sticks of health care workers in which the needles—the needle had

some blood or body fluid from a person, from an individual who had HIV infection. In some of these reports the amounts of blood or body fluids have been extremely small, almost miniscule and yet they have resulted in transmission of the virus to these health care workers.

In addition, there have been six other cases reported not involving needle sticks. Three of these cases were reported in the May 22nd issue of the *MMWR* in which three health care workers were either splashed with blood on their skin or mucous membrane in their mouth and subsequently seroconverted, developing HIV antibody. (p. 910: 1-25) Some of them had the acute viral syndrome of acute HIV infection.

There are also other reports, one of a mother taking care of an HIV-infected infant at her home who had exposure to blood and body flunds taking care of this infant who subsequently became infected.

In addition, there is a report in the *Lancet*, I believe it is September of 1986, in which a young boy with AIDS bit his older brother and the older brother subsequently developed or seroconverted, developing HIV infection, and this child, the older brother, had no other risk factor for HIV infection, and the parents were both sero negative so it was not acquired perinatally and there was also any denial of sexual abuse of this older brother. The only risk factor that could be found from this was a bite from the younger brother, and I have that report if you want to—with me if you want to submit that as an exhibit or read it, because that is very disturbing, that a bite—and it was not even a severe bite. In fact, it was not even clear that it drew blood at all from this bite.

So those reports are disturbing and there has recently been reported a dentist who became infected. Now, this dentist had seen many patients and had not worn gloves, especially before this year, and had been exposed to blood and saliva of patients in his dental work but did not recall (p. 911:1-22) any routine needle stick or puncture from an HIV-infected patient though he may have had punctures in needle sticks some time in the past.

But here are fifteen cases that, you know, raises an alarm that this can appear to occur. It may not—it may be unusual or low frequency but it does appear that it can occur, and those incidents, like I say, are not so much different from those described in these incident reports, and more recent scientific evidence has shown that in fact there are cells in the skin, in the epidermis, which is the upper layer of the skin, which have receptors for the—for HIV, and in at least twenty per cent of AIDS cases have been shown that these cells in the skin layer are infected with the HIV virus, as detected by the actual viral DNA or viral proteins. So it is not inconsistent, although there is a foundation scientifically how these transmissions can occur and that there do appear to be cells, for instance in the skin, that exposed to virus from a body fluid or blood could infect those cells, and it may be even small abrasions, maybe not even visible to the eye, that are there and could result in this type of transmission. I think it's low but I think it exists.

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(p. 917:4-25) Q. Doctor, Dr. Gottlieb testified on the risk of transmission in the ENCOR setting to be a

probability of low to non existence. Dr. Goldsmith testified at trial on the same subject matter as the risk of transmission to be trivial to zero. Do you disagree with those opinions and, if so, why?

A. Well, I don't agree that the risk is nonexistent. These incidents at ENCOR which in one of these exhibits, for instance, Exhibit Number, I think 132, showed at least some 106 bites and 238 scratches of which about 40 had—it had been documented that there had been blood involved in those cases. I think these are similar to the cases I have mentioned before, these other documented exposures reported by CDC and other reports in the literature. So I think—you know, if it not nonexistent. These types of exposures have resulted in transmission of HIV infection. It is not nonexistent.

However, when they say it's essentially zero or very trivial, I suppose, you know, one wants to know how low is that to them. Is that one in a hundred? Is that one in 10,000? Is that one in 100,000? And to give you an example of what I mean by that, in Minnesota in the last 18 months at our blood center, at Red Cross, we screened (p. 918:1-11) 300,000 blood donors and we found two HIV antibody-positive donors, so, in other words, if we didn't screen, the risk of getting HIV infection from a blood unit would be one in 150,000. That seems like very low. Maybe that seems like essentially zero, one in 150,000, and yet patients in Minnesota as well as the FDA, the CDC, has found a one-in-150,000 risk unacceptable. They have required mandatory screening for these blood donors and, you know, these blood donors, you know, they want to help these patients by giving their blood and are perfectly

willing to undergo mandatory screening if it means a safer blood supply.

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(p. 921:17-20; 22-25) Q. Doctor, in light of the factors relating to transmission that you just testified to and based on your experience and education, do you have an opinion as to whether the mandator testing that ENCOR is seeking is medically justified?

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A. Yes.

Q. And what is that opinion?

A. My opinion on this matter is until more is known about the frequency of transmission of HIV infection due to (p. 922:1-25) these type of exposures involving relatively small amounts, miniscule amounts of blood or body fluids, that this is a reasonably and prudent course to take in order to prevent transmission.

In addition, I should point out that there is some benefit to the staff of being tested in that if they were to be found positive, in this setting they are actually at increased risk of acquiring infections, opportunistic infections, from these clients due to their personal hygiene.

For instance, one of the reports, incident reports, on Plaintiffs' Exhibit 34, shows one of the clients attacked the staff and had feces excrement in his fingernails when trying to grab the staff around the neck. Now, feces and excrement contain bacteria that can cause severe disease in HIV-infected individuals.

Clients, mentally retarded clients, have also been—or mentally handicapped clients, I guess, or patients have been shown to have higher incidence of cytomegalovirus infection, a real killer in HIV-infected individuals, hepatitus B virus. So, in fact, one might consider, you know, removing a staff if HIV-infected, not only to protect the client but also to protect the staff person themselves from these infectious agents that are—I would submit are in higher—not incidence, but prevalence within these settings.